

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED  
OMB NO. 0938-0391

45# 4/19/14

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445314	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/05/2014
---	---	--	---

NAME OF PROVIDER OR SUPPLIER  FE CARE CENTER OF MORRISTOWN	STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST ECONOMY ROAD MORRISTOWN, TN 37814
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272 SS-D	<p><b>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</b></p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:                      Identification and demographic information;                      Customary routine;                      Cognitive patterns;                      Communication;                      Vision;                      Mood and behavior patterns;                      Psychosocial well-being;                      Physical functioning and structural problems;                      Continence;                      Disease diagnosis and health conditions;                      Dental and nutritional status;                      Skin conditions;                      Activity pursuit;                      Medications;                      Special treatments and procedures;                      Discharge potential;                      Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and                      Documentation of participation in assessment.</p>	F 272	<p><u>Corrective Action:</u> For resident #122 the MDS was corrected on 3/13/14 to reflect resident #122's missing and decayed teeth by MDS Coordinator.</p> <p><u>Residents with Potential to be Affected:</u> All residents have the potential to be affected. A 100% audit of all current residents Dental Status are compared to their MDS to assure accurate coding and completion of the MDS completed by 3/19/14 by DON, ADON, and other Nursing Administration.</p> <p><u>Systematic Changes:</u> Review and Education was provided to MDS Coordinators on proper and accurate coding by DON on 3/13/14, MDS Coordinator educated to assess residents dental status and review the oral assessment when completion of the oral section of the MDS.</p>	<p>3/13/14</p> <p>3/19/14</p> <p>3/13/14</p>

ATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Brigitt Holliday, Executive Director</i>	TITLE <i>3/19/14</i>	(X6) DATE
---	-------------------------	-----------

iciency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days from the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445314	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/05/2014
---	---	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIFE CARE CENTER OF MORRISTOWN

501 WEST ECONOMY ROAD  
MORRISTOWN, TN 37814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 1  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to accurately assess dental status for one resident (#122) of twenty-nine residents reviewed.  The findings included:  Resident #122 was admitted to the facility on October 16, 2013, with diagnoses including Alzheimer's Disease, Parkinson's Disease, Anxiety Disorder, and Chronic Lung Disease.  Review of an Admission Minimum Data Set (MDS) dated October 23, 2013, revealed the resident was severely cognitively impaired and did not have any missing or decayed teeth.  Observation of the resident on March 4, 2014, at 9:55 a.m., in the resident's room, revealed the resident had multiple missing and decaying teeth.  Interview with Licensed Practical Nurse (LPN) #1 and Registered Nurse (RN) #1 on March 5, 2014, at 9:58 a.m., in the Conference Room, confirmed the resident had multiple dental problems and the MDS assessment dated October 23, 2013, was inaccurate.	F 272	<u>Monitoring:</u> A Performance Improvement Plan was initiated on 3/5/14 addressing education, audit and monitoring of Dental Assessments for MDS being completed appropriately on all residents. DON, ED, Medical Director, ADON, other Nursing Administration and other facility Department Managers reviewed the Performance Improvement plan during monthly Performance Improvement Meeting on 3/14/14. An audit will be completed weekly on all new admissions' MDS's for six weeks by DON, ADON and other Nursing Administration to ensure accurate MDS dental assessments with a completion date of 4/24/14. The MDS dental assessments will then be audited by DON, ADON, and other Nursing Administration randomly and as needed.	3/5/14
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309	<u>Corrective Action:</u> For resident #117 foot rests were immediately applied to residents Broda chair on 3/3/14 by RN unit Manager. Education was immediately completed by RN unit Manager to staff caring for resident #117 on the necessity for foot rests to be applied to Broda chair.	3/3/14

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF MORRISTOWN	501 WEST ECONOMY ROAD MORRISTOWN, TN 37814

1 CMS-2567(02-99) Previous Versions Obsolete
Event ID: ENAP11
Facility ID: TN3202
If continuation sheet Page 3 of 9

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445314	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF MORRISTOWN	STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST ECONOMY ROAD MORRISTOWN, TN 37814
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 3</p> <p>revealed the chair did not have a foot rest attached. Continued observation revealed the resident's lower extremities were slightly edematous (swollen) at the ankles. Continued observation revealed the resident was severely cognitively impaired, was unable to follow commands, and spoke in garbled sentences. Continued observation revealed the resident could not reposition the lower extremities independently in the chair.</p> <p>Observation on March 3, 2014, from 12:15 p.m. to 12:20 p.m., revealed a facility staff member transported the resident to the dining area in the broda chair, and did not attempt to reposition the resident's legs.</p> <p>Observation of the resident in the East Wing Dining Area on March 3, 2014, from 12:20 to 12:25 p.m., revealed the resident seated in the broda chair in the same position as previously observed, being assisted by a staff member with the meal.</p> <p>Observation with Registered Nurse #2 (RN #2) who was the unit manager, on March 3, 2014, at 12:26 p.m., in the dining area, revealed the posterior surface of the resident's calves bilaterally exhibited red marks identical in size and shape to the straps of the chair.</p> <p>Interview with RN #2 on March 3, 2014, at 12:27 p.m., in the dining area, confirmed the chair was to have a footrest attached, the resident's legs and feet were not properly supported in the chair, and the facility failed to maintain proper body positioning of the dependent resident.</p>	F 309	<p><u>Monitoring:</u></p> <p>A 100% audit will be completed daily for two weeks to ensure all ordered positioning devices are in place for residents by DON, ADON, and other Nursing Administration with completion date of 3/19/14. A 100% audit will be completed weekly for a month to ensure all ordered positioning devices are in place for residents by DON, ADON, and other Nursing Administration with completion date of 4/1/14, and then they will be audited randomly and as needed. A Performance Improvement Plan was initiated 3/5/14 to address procedure for position devices and reviewed during facility Performance Improvement meeting on 3/14/14 with attendance by ED, DON, ADON, Medical Director, Nursing Administration, and other Department Managers.</p>	3/5/14
F 371	483.35(i) FOOD PROCURE,	F 371		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/10/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445314	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/05/2014
---	---	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIFE CARE CENTER OF MORRISTOWN

501 WEST ECONOMY ROAD  
MORRISTOWN, TN 37814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371 SS=F	Continued From page 4  STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure outdated foods were not available for residents, and failed to ensure dirty food carts were not stored in clean areas of the kitchen.  The findings included:  Observation on March 3, 2014, at 9:15 a.m., in the kitchen, revealed one jar of Pimento Cheese in the refrigerator labeled, "...opened February 24, 2014...discard February 27, 2014..."  Interview with the Dietary Manager on March 3, 2014, at 9:15 a.m., in the kitchen, confirmed the Pimento Cheese was expired and was available for the residents.  Observation on March 4, 2014, at 2:00 p.m., in the dishwashing area of the kitchen, revealed one uncovered dirty food storage cart with dirty food trays stored on the cart. Further observation revealed the uncovered dirty food storage cart was stored in the same area where clean plates, clean cooking pans, and clean serving trays were	F 371	<u>Corrective Action:</u> Jar of pimento cheese was immediately discarded by Dietary Manager on 3/3/14. <u>Residents with Potential to be Affected:</u> All residents have the potential to be affected. A 100% audit of all food items in refrigerator, freezer, and dry storage was completed by Dietary Manager on 3/3/14 to ensure all food was stored under sanitary conditions. <u>Systematic Changes:</u> Review and Education completed with all dietary staff on 3/12/14 by Dietary Manager on Policies and procedures for storing food under sanitary condition. All food must have label with name of product, date made or brought out of freezer and use by date. All items must not be used later than the use by date. If food item is past use by date it must be disposed of immediately and not used. <u>Monitoring:</u> A Performance Improvement Plan was initiated 3/3/14 to address procedures for sanitary storage of food items. The Performance Improvement Plan was reviewed during facility Performance Improvement Meeting on 3/14/14 and attended by ED, DON, ADON, Medical Director, Nursing Administration, and other Department Managers. A 100% audit of all food items in refrigerator, freezer, and dry storage will be completed by Dietary Staff and Manager daily for two weeks with a completion date of 3/17/14. A 100% audit will then be completed weekly by Dietary Staff and manager during kitchen weekly audit indefinitely.	3/3/14  3/3/14  3/12/14  3/3/14









DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/10/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445314	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/05/2014
---	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF MORRISTOWN	STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST ECONOMY ROAD MORRISTOWN, TN 37814
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 6</p> <p>from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to perform hand hygiene during incontinence care for one resident (#23) of twenty-nine residents reviewed.</p> <p>The findings included:</p> <p>Resident #23 was admitted to the facility on December 31, 2012, with diagnoses including Hypertension, Dementia, Anxiety, Depression, Chronic Obstructive Pulmonary Disease, and Pressure Ulcer.</p> <p>Review of the Quarterly Minimum Data Set dated January 10, 2014, revealed the resident had a urinary catheter and required extensive assistance with all activities of daily living.</p> <p>Observation of incontinence care on March 4, 2014, at 2:45 p.m., in the resident's room, revealed Licensed Practical Nurse (LPN) #2 donned gloves and wiped large amounts of loose feces from the resident's gluteal area using</p>	F 441	<p>Corrective Action:</p> <p>Review and Education provided to LPN #2 regarding infection control policies and procedures by DON on 3/14/14.</p> <p>Residents with Potential to be Affected: All residents have the potential to be affected.</p> <p>Systematic Changes: Review and Education provided to all licensed nursing personnel regarding infection control policies and procedures by Staff Development Coordinator on 3/14/14.</p> <p>Monitoring: A Performance Improvement Plan was initiated on 3/5/14 to address infection control concerns with hands not being washed and gloves not changed before touching a clean item during resident care. The Performance Improvement Plan was reviewed during the facility Performance Improvement Meeting on 3/14/14 with ED, DON, ADON, Medical Director, Nursing Administration, and other Department Managers. A audit is being completed daily for two weeks by DON, ADON, and other Nursing Administration to observe staff during residents care to ensure infection control policies and procedures are being followed with a completion date of 3/19/14. An Audit will then be completed by DON, ADON, and other Nursing Administration weekly of random staff</p>	<p>3/14/14</p> <p>3/14/14</p> <p>3/5/14</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED  
OMB NO. 0938-0391

TATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445314	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/05/2014
---	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF MORRISTOWN	STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST ECONOMY ROAD MORRISTOWN, TN 37814
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 7 disposable wipes. Continued observation revealed LPN #2 opened the drawer of the resident's bed side table and obtained additional supplies, without removal of the soiled gloves or washing the hands, and resumed wiping additional feces from the resident's gluteal area and perineum.  Review of the facility policy Hand Hygiene revised May 1, 2012, revealed, "...when hands are visibly dirty or contaminated...or are visibly soiled with blood or other body fluids...wash hands..."  Interview with LPN #2 on March 4, 2014, at 3:40 p.m., at the nursing station, confirmed the LPN failed to remove the soiled gloves or wash the hands prior to opening the resident's bedside table, and failed to follow the hand hygiene policy during the procedure.	F 441	member during resident care to ensure infection control policies and procedures are followed for six weeks with a completion date of 4/24/14.	
F 502 SS=D	483.75(j)(1) ADMINISTRATION  The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.  This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure laboratory tests were obtained as ordered for one resident (#42) out of twenty-nine residents reviewed.  The findings included:  Resident #42 was admitted to the facility on September 3, 2010, and readmitted to the facility	F 502	<u>Corrective Action:</u> For resident #42 physician was immediately notified by the DON on 3/4/14. The lab was drawn on 3/4/14 for Hepatic function per physician orders with no concern noted per physician. The Lipids and TSH lab was drawn per physician order on 3/5/14 due to fasting necessary, with no concerns noted per physician with results.	3/4/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445314	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/05/2014
---	---	--	---

NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF MORRISTOWN	STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST ECONOMY ROAD MORRISTOWN, TN 37814
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	Continued From page 8 on March 28, 2011, with diagnoses including Muscle Weakness, Explosive Personality Disorder, Depressive Disorder, Anxiety, Unspecified Psychosis, Obstructive Hydrocephalus, Osteochondroma, Organic Traumatic Brain Syndrome, and History of Deep Vein Thrombosis.  Review of the Physician's monthly recapitulation orders dated March 2014, revealed laboratory orders for Lipids and TSH (Thyroid Stimulating Hormone blood test used to determine how well the thyroid gland is functioning) every three months (October/January/April/July), with an origin date of April 27, 2011, and orders for Hepatic Function Panel every three months (October/January/April/July), with an origin date of June 9, 2011.  Medical record review revealed no laboratory results for the Lipids, TSH, and Hepatic Function Panels for the months of January or February 2014.  Interview with the Director of Nursing on March 5, 2014, at 10:45 a.m., at the East Wing nursing station, confirmed the Hepatic Function Panel, TSH, and Lipids had not been obtained in January as ordered.	F 502	<u>Residents with Potential to be affected:</u> All residents with labs ordered per physician have the potential to be affected. A 100% Audit was completed by DON, ADON, and Nursing Administration of all ordered labs to be compared with listing of ordered labs per physicians toe ensure completion and accuracy with a completion date of 3/12/14.  <u>Systematic Changes:</u> Review and Education to Nursing Administration by DON on 3/13/14 of any new lab order will be reviewed during clinical meeting daily and compared with lab notebook for each unit to assure that lab requisitions, and documentation of labs has been completed.  <u>Monitoring:</u> A Performance Improvement Plan was initiated on 3/4/14 to ensure that labs are drawn per physician orders. The Performance Improvement Plan was reviewed during the facility Performance Improvement Meeting on 3/14/14 with ED, DON, ADON, Medical Director, Nursing Administration, and other Department Managers. Ordered labs listings are to be included in weekly reports from pharmacy and will be audited by DON, ADON, and other Nursing Administration weekly for any changes for two months with a completion date of 5/7/14, then monthly	3/12/14   3/13/14   3/4/14

Facility for two months with a completion date of sheet Page 9 of 9  
7/9/14.